# The Health Care Workforce Working Group (HCWWG)

**Meeting Agenda**

**November 13, 2025**

**12:00 P.M. To Adjournment**

**This meeting is being held virtually. The public is invited to attend the event.**

**Meeting Locations**

**Physical Location**
10375 Professional Circle
Reno, NV 89521
Third Floor / Walker Room

**Virtual Information**
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NOTICE:

1. The agenda items may be taken out of order.
2. Two or more items may be combined; and
3. Items may be removed from the agenda or delayed at any time.

**1. Call to Order and roll call**

**2. Public Comment**

Public comment may be presented in-person, by computer, phone, or written comment. No action may be taken upon a matter raised under public comment unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, dial 775-321-6111. When prompted to provide the Meeting ID, enter 109 193 753# Due to time considerations, each individual offering public comment will be limited to not more than five (5) minutes. A person making comment will be asked to begin by stating their name for the record and to spell their last name. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted electronically before, during, or after the meeting by emailing Mitch DeValliere at bdevalliere@health.nv.gov. You may also mail written documents to the Division of Public and Behavioral Health, 4150 Technology Way, 3rd. Floor, Carson City, NV 89706.

**3. For Possible Action**

Discussion and possible action for approval of October 16, 2025, Meeting Minutes

**4. For Information Only**

A Roadmap for Enhancing State Health Workforce Data: Implementing the Cross-Profession Minimum Data Set – Dr. Hannah Maxey, Director, Bowen Center for Health Workforce Research and Policy, Indiana University School of Medicine

**5. For Information Only**

Discussion to establish a health care provider database per NRS 439A.116

**6. For Possible Action**

Discussion and possible action to establish **meeting schedule** and **future agenda** items for November and January.

**7. Public Comment**

Public comment may be presented in-person, by computer, phone, or written comment. No action may be taken upon a matter raised under public comment unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, dial 775-321-6111. When prompted to provide the Meeting ID, enter 109 193 753#.



Bureau of Child, Family and Community Wellness
4150 Technology Way, Suite 210 ● Carson City, NV 89706 ● (775) 684-4200 ● Fax (775) 687-7570 ● dpbh.nv.gov

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## 8. Adjournment

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**Physical Posting Locations**

- Division of Public and Behavioral Health – 4150 Technology Way, 1st Floor, Carson City

**Internet Postings**

- Division of Public and Behavioral Health website: https://dpbh.nv.gov/Boards/HCWWG/hcwwg-information/

It is the goal of this body to provide at least two (2) public comment periods in compliance with the minimum requirements of the Open Meeting Law prior to adjournment, pursuant to Nevada Revised Statutes 241. No action may be taken on a matter raised under public comment unless the item has been specifically included on the agenda as an item upon which action may be taken. The Chair retains discretion to only provide for the Open Meeting Law's minimum public comment and not call for additional item-specific public comment when it is deemed necessary by the chair to the orderly conduct of the meeting.

This meeting is a public meeting, recorded and held in compliance with and pursuant to the Nevada Open Meeting Law, pursuant to NRS 241. By Participating, you consent to recording of your participation in this meeting. All voting members should leave their cameras on for the duration of the meeting and refrain from entering any information into the chat function of the video platform. Please understand the use of obscenities or other behavior which disrupts the meeting to the extent that its orderly conduct is made impractical may result in forfeiture of the opportunity to provide public comment or removal from the meeting.

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If at any time during the meeting, an individual who has been named on the agenda or has an item specifically regarding them, including on the agenda is unable to participate because of technical difficulties, please notify Mitch DeValliere (775) 431-7144 or by email at bdevalliere@health.nv.gov and note at what time the difficulty started to that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise

addressed.

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Supporting material for this meeting can be obtained at: Division of Public and Behavioral Health, 4150 Technology Way, Suite 210, Carson City, NV 89706, or by calling Mitch DeValliere (775)431-7144 or via email at bdevalliere@health.nv.gov.

Anyone who would like to be on the Health Care Workforce Working Group mailing list must submit a written request every six months to the Nevada Division of Public and Behavioral Health at the address listed below.

If you have difficulties with the hyperlink for the meeting provided above, please try copy and pasting the following address:
**https://teams.microsoft.com/l/meetup-join/19%3ameeting_NGQ3ZmVmZTQtMWExYS00ZWU5LWJhY2YtZjc3MjBmNGJiYzY1%40thread.v2/0?context=%7b%22Tid%22%3a%22e4a340e6-b89e-4e68-8eaa-1544d2703980%22%2c%22Oid%22%3a%2274a090ee-3b27-47a6-b5b0-98c1cfa1aea6%22%7d**



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# HEALTH CARE WORKFORCE WORKING GROUP MINUTES

## October 16, 2025

## 1:00 PM

The Health Care Workforce Working Group held a public meeting on 10/16/25, beginning at 1:00 PM, held at the following location:

Virtual location only

## Working Group Members Present

Chair John Packham, Associate Dean, University of Nevada, Reno School of Medicine
Krisann Alvarez, Licensed Psychologist, Division of Child and Family Services
Mitch DeValliere, Agency Manager, Division of Public and Behavioral Health
Frank DiMaggio, Executive Director, Nevada State Board of Osteopathic Medicine
Victoria "Vikki" Erickson, Executive Director, Board of Examiners for Social Workers
Joelle McNutt, Executive Director, State of Nevada Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors
Sarah Restori, Administrative Director, Nevada Board of Psychological Examiners

## Working Group Members Not Present

Edward Cousineau, Executive Director, Nevada State Board of Medical Examiners
Tyree Davis, Chief Medical Officer for Ancillary Services, Nevada Health Center
Cathy Dinauer, Executive Director, Nevada State Board of Nursing
Adam Higginbotham, Executive Director, Nevada State Dental Board
Jose Melendrez, Executive Director, University of Nevada, Las Vegas, School of Public Health
Steve Messinger, Policy Director, Nevada Primary Care Association
David Wuest, Executive Secretary, Nevada State Board of Pharmacy

## Others Present:

**North Carolina: Katherine Moore, UNC Sheps Center**
**South Carilina: Katie Gaul, AHEC**
**New York: Jean Moore, SUNY Albany**

Aileen Y Lovitt, University of Nevada, Reno
Nicole K. Mwalili, University of Nevada, Reno
Sarah Hartzell, University of Nevada, Reno
Tabor Griswold, University of Nevada, Reno
Sara Hunt, BeHERE NV
Micki Golden, Accreditation Analyst, Division of Public and Behavioral Health

Ruby Kelly
Yuhan Bi

## 1. Call to Order and Roll Call

- Roll call was taken and determined a quorum of the Health Care Workforce Working Group (HCWWG) was present, per Nevada Revised Statute (NRS) 439.51
- Mitch DeValliere acknowledged that the meeting was being recorded to facilitate transcription.

## 2. Public Comment

Chair Packham invited public comment at approximately 1:06 PM.

**No public comment received.**

## 3. FOR POSSIBLE ACTION — Approval of July 24, 2025, Meeting Minutes

Chair Packham introduced the item.

**Discussion:**

- Member **Krisann Alvarez** requested a correction: her affiliation was listed incorrectly as "Nevada Health Authority" and should be **Division of Child and Family Services.** The Chair acknowledged the correction.

**Action:**

- **Motion:** Approve July 24, 2025, Meeting Minutes with correction
- **Moved by:** Victoria Erickson
- **Second:** Joelle McNutt
- **Vote:** Passed unanimously; no opposition noted

## 4. FOR INFORMATION ONLY — Workforce Data Collected by Licensing Boards

Chair Packham summarized current workforce data collection practices among Nevada licensing boards.

**Highlights:**

Review of responses from 8 licensing boards regarding 16 data elements required by legislation.

- **Notable findings:**
    - **County where licensee works:** Only 2 of 8 boards collect this data; 6 do not.
    - **Practice location:** 5 of 8 boards collect; 3 do not.
    - **Hours worked:** Nearly no boards collect this; limited voluntary collection by social work Board.

- **Type of patients served:** Only 2 of 8 boards collect.
- **Telehealth utilization:** None (0/8) collect.
- **Practice/employment plans for next 5 years:** None (0/8)collect.

No questions from members were recorded.

## 5. FOR INFORMATION ONLY — Model Practices from Other States

Chair Packham introduced guest speakers representing state health workforce research centers.

Guest Presentations (Summarized):

**New York — Jean Moore, SUNY Albany**

- Center active since 1996
- Collects data through re-registration; some historical challenges transitioning from mail to digital systems
- Pandemic spurred new data requirements
- Nursing burnout data collection provided major insights

**North Carolina — Katherine Moore, UNC Sheps Center**

- Data collection initiated in the 1970s
- Multi-board participation is voluntary
- Database reflects ~21 healthcare professions across 11 boards
- Highly used to inform policy (e.g., nursing program funding)

**South Carolina — Katie Gaul, AHEC**

- Data collection also dates back to 1970s
- State funding supports research; emphasis on nursing workforce
- Licensing data collected every two years
- Focus on minimal burden on licensees

**Discussion Themes:**

- Development of minimum data sets (MDS)
- Data governance / consent structures
- Separating applicant vs. licensee data
- Workforce supply/demand tracking
- Partnerships between academia, state, and philanthropy

## 6. FOR POSSIBLE ACTION — Meeting Schedule & Future Agenda Items

Scheduling discussion held near end of meeting.

**Discussion Summary:**

- **Next meeting scheduled for November 13, 2025**
- Chair Packham proposed shifting meeting start time to **12:00 PM Pacific** (3–5 PM Eastern) at the request of a guest speaker
- Members present agreed; no objections recorded
- Dr. DeValliere will send calendar invitation and confirm quorum

**Action:**

- **Motion:** Adjust November meeting time to 12:00 PM PT
- **Moved by:** *Consensus—no formal mover identified*
- **Second:** N/A
- **Vote:** Passed by consensus; no objections noted

Future scheduling for **December or January** will be considered at November meeting.

### 7. Public Comment #2

Chair Packham opened the floor for additional public comment.

**No public comment received.**

### 8. Adjournment

Chair Packham thanked members and adjourned the meeting.

## Next Meeting

November 13, 2025

12:00 PM – 2:00 PM PT

Virtual (Microsoft Teams) HCWWG_Meeting 11/13/25

# Follow-up Items

| Item | Lead |
|---|---|
| Correct minutes for July 24, 2025 to update member affiliation | Staff |
| Send November 13 meeting invite at adjusted time | Mitch DeValliere |
| Confirm quorum for November meeting | Mitch DeValliere |
| Future agenda: Determine December vs. January meeting | Chair / Group |

HRRI
Healthcare Regulatory Research Institute

# A ROADMAP FOR ENHANCING STATE HEALTH WORKFORCE DATA:

## IMPLEMENTATION GUIDE FOR THE CROSS-PROFESSION MINIMUM DATA SET

Developed by Veritas Health Solutions With Support Provided by the Health Regulatory Research Institute: August 2023

VERITAS HEALTH SOLUTIONS

# ACKNOWLEDGEMENTS

**Citation: Maxey H, Medlock C. A Roadmap for Enhancing State Health Workforce Data: Implementation Guide for the Cross-Profession Minimum Data Set. 2023.**

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SPONSORED BY

**Healthcare Regulatory Research Institute**
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AUTHORED BY

**Veritas Health Solutions**
**For questions or feedback on this document, reach out to us at admin@veritashealthsolutions.org.**

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# INTRODUCTION

## MAKING THE CASE FOR HEALTH WORKFORCE DATA

Access to health workforce data is essential to inform various aspects of policy and programs, such as identifying health workforce shortage areas, planning for educational programs or regulatory policy changes, forecasting employment demands, and justifying funding requests. Detailed information about the health workforce is necessary to evaluate existing programs and to plan for future needs.

Health workforce policy and planning cannot be done in a silo. The health workforce includes an array of professions, differing in training, focus and scope. Some contributions are unique, others overlap, many are synergistic. Regardless of differences or similarities, all health professions share a common mission to contribute to the health of the people and communities they serve. When the contributions of different health professions are coordinated and synergies in care achieved, patient outcomes can be improved. Consistent workforce data across health professions is needed to inform policy and planning.

## WHAT HAS BEEN DONE AND WHERE ARE THE GAPS?

Health workforce data collection has been a national priority for decades. The Health Resources and Services Administration (HRSA), in collaboration with national organizations, established minimum data set survey tools for several health professions in 2013. Great care was taken to develop surveys that met the data needs of each respective profession, but unfortunately, coordination between professions to ensure alignment across surveys for data elements common to all professions did not occur. Inconsistencies in data collection strategies (questions and response options) for data elements such as demographics threaten cross profession comparison and analysis.

## A CALL TO ACTION

In the face of pervasive workforce shortages, health workforce data collection has emerged as a top national and state priority. Now, more than ever before, a Cross-Profession Minimum Data Set (CPMDS) is needed to ensure consistency, where appropriate, in health workforce data. In 2022, seven national organizations came together to review existing survey tools and prepare the CPMDS to serve as a resource to the federal and state governments, organizations, and researchers seeking to collect health workforce data. Broad adoption of the CPMDS will streamline current and support future initiatives by ensuring comparability across health professions data.

## ABOUT THE CPMDS

The CPMDS is a set of core questions for collecting data elements widely considered the "minimum necessary" for health workforce planning. The intent of the CPMDS is to serve as a framework for standardizing data collection across various health professions for the purpose of supporting within and between profession comparisons and analyses. As a framework, the CPMDS questions have been designed with varying levels of standardization. For example, the CPMDS provides standardized questions and response options for data elements that are consistent across the professions (example: demographics) but includes flexible questions and response options for data elements requiring customizations (example: specialty and setting). The CPMDS provides a framework upon which individual profession-specific tools can be developed.


**OPPORTUNITY FOR ACTION**

Download the CPMDS tool, or access the CPMDS with FAQs document for additional information, context, and considerations for implementation.

# ROADMAP

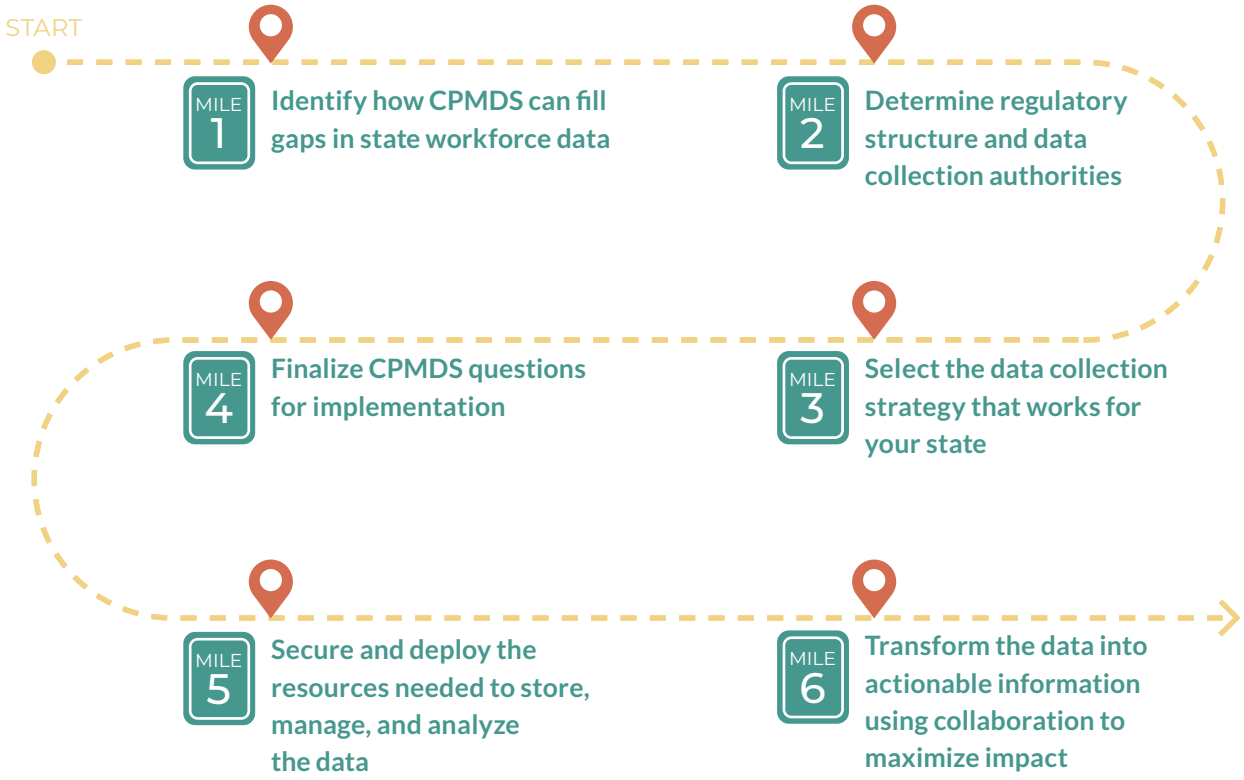
The CPMDS has broad application potential. Any initiatives related to health workforce data collection may benefit the structure it provides; however, states and state regulators/licensing boards are uniquely positioned to support routine health workforce data collection from licensed health professionals at the time of license application and renewal. Many states are actively engaged in or currently pursuing opportunities to do so for one or more licensed health profession. In some instances, such data collection is statutorily authorized. In fact, as of 2023 several states have enacted statutes authorizing workforce data collection from one or more licensed professions and others are considering legislative initiatives. These state-based workforce data collection initiatives directly inform government policy and planning, but they are also useful to the private sector.

## TARGET AUDIENCE

This roadmap has been designed to support states and state regulators/licensing boards on implementation of the CPMDS.

## TABLE OF CONTENTS

It includes useful information and actionable tools organized to support informed implementation at seven critical stages:



# ROADMAP IMPLEMENTATION

**USE THE CHECKLIST BELOW TO IMPLEMENT THE CPMDS IN YOUR STATE.**

## ☐ IDENTIFY HOW CPMDS CAN FILL GAPS IN STATE WORKFORCE DATA

Explore what information is currently captured from health professionals in your state during the licensing process.

- Corresponding Roadmap pages: 6-7
- Corresponding Tools and Resources: Explore the Health Workforce Technical Assistance Center's Health Workforce Data Collection Inventory, the supplemental resource on national health workforce data sources, and complete Tool A: Understanding Your State Licensing Data

## ☐ DETERMINE REGULATORY STRUCTURE AND DATA COLLECTION AUTHORITIES

A first step toward expanding data collection is understanding the current environment within your state for occupational regulation, administrative resources, and current data collection authorities.

- Corresponding Roadmap page: 9-12
- Corresponding Tools & Resources: Explore this review of other state's statutory authority for data collection and complete Tool B: State Occupational Regulation & Administrative Resources.

## ☐ SELECT THE DATA COLLECTION STRATEGY THAT WORKS FOR YOUR STATE

Use the decision matrix tool to determine your state's profession of interest, understand existing authorities, and appropriate next steps by profession.

- Corresponding Roadmap pages: 13-14
- Corresponding Tools & Resources: Tool C: Professions, Authority & Action

## ☐ FINALIZE CPMDS QUESTIONS FOR IMPLEMENTATION

Once you've determined your next step for each profession, the profession-specific survey tools must be prepared. Explore the considerations and resources listed on the links below to develop these surveys, then implement the surveys according to your state's preferred data collection modality.

- Corresponding Roadmap pages: 15-19
- Corresponding Tools & Resources: Review the CPMDS, associated CPMDS FAQ document, and Profession specific surveys to support CPMDS implementation. Tools D: State Health Workforce Data Needs and E: Stakeholder Inventory will highlight important considerations for survey development.

## ☐ SECURE AND DEPLOY THE RESOURCES NEEDED TO STORE, MANAGE, AND ANALYZE THE DATA

Identify the data resources you need to prepare the data once it is collected. Determine the most appropriate approach and implementation model for data storage, management, and analysis.

- Corresponding Roadmap pages: 20-21
- Corresponding Tools: Review a brief on collaborating with licensing bodies and the implementation models referenced on page 20.

## ☐ TRANSFORM THE DATA INTO ACTIONABLE INFORMATION USING COLLABORATION TO MAXIMIZE IMPACT

Once the data are cleaned and available, prepare a plan for reporting to maximize its impact.

- Corresponding Roadmap pages: 22-24
- Corresponding Tools: To address individual state data needs, complete Column H on Tool E: Stakeholder Inventory. To support coordinated health workforce planning potential, review the state models referenced on pages 22-24 to determine if a coordinating entity might be appropriate for your state. If there is a desire to develop a forum in your state, use Tool E: Stakeholder Inventory to consider the perspectives that could be brought to the table.

MILE 1

# Identify how CPMDS can fill gaps in state workforce data

## GOOD: DATA ARE NOT GRANULAR OR COMPREHENSIVE, BUT ARE COMPARABLE

### WHAT SECONDARY HEALTH WORKFORCE DATA IS ALREADY AVAILABLE FOR YOUR STATE?

There are a number of secondary data sources that may already be available to meet a state's health workforce data needs. Many times, states find that these information sources are either not granular or sufficiently comprehensive to inform policy or planning. Check out Appendix A to explore what information might be available today from national organizations.

**Using Secondary Health Workforce Data**

**Benefits**

- Readily accessible
- Generally no-to-low cost (with some exceptions)

**Challenges**

- Lack of granularity
- Limited comparability between professions
- Inability to link to other data sources

## BETTER: DATA ARE GRANULAR BUT NOT COMPREHENSIVE OR COMPARABLE.

### WHAT PRIMARY HEALTH WORKFORCE DATA IS ALREADY AVAILABLE IN YOUR STATE?

Many states already have some level of health workforce data that is already collected and available within your state. The key to leveraging primary data is understanding 1) where the data is collected and housed, and 2) what specific information is available. The Health Workforce Technical Assistance Center is an entity that is funded by HRSA to provide technical assistance to state health workforce planning. This Center maintains a State Health Workforce Data Collection Inventory that includes information on health workforce supply or demand data. This inventory includes data collected through the licensing process, telephone interview, in-person interview, or other means.

**Did you know?**

**36 states** collect health workforce supply data, but only **28 states** collect this data as a part of the licensing process, and there are wide variations on which profession types are included.

Learn more about health workforce data that may already be collected in your state.

**Using Primary Health Workforce Data from Any State-based Source**

**Benefits**

- More robust information about your state's workforce
- State-based expertise that can support analyses

**Challenges**

- Information and collection strategies may vary by profession resulting in limited comparability between professions
- Information may not be linkable to other state data sources

WALK

**OPPORTUNITY FOR ACTION**

Explore what information is currently captured from health professionals in your state during the licensing process by visiting Tool A: Understanding Your State Licensing Data and talking with your state regulatory boards/agency.

## BEST: DATA ARE GRANULAR, COMPREHENSIVE, AND COMPARABLE TO OTHER STATES.

### WHAT PRIMARY HEALTH WORKFORCE DATA COULD YOU BE COLLECTING?

Given the variations in health workforce data collection between professions and between states, there has been an identified need for coordinated efforts. As described in the introduction of this toolkit, there has never before been a cross-profession tool that allows for standardization in the information that is available to support state policy.

**Data available to support state planning must be:**

- **Comprehensive -** Include all health professionals practicing in the state
- **Granular -** Has individual-level detail to support coordination with other state data sources, such as educational records, a P20W database, or Medicaid provider enrollment
- **Comparable -** States need to both have information at the profession-specific level, but also be able to report on the entire state health workforce using comparable data across professions.

The CPMDS tool was developed in consideration of the various state policies or programs that can be informed by health workforce data, including occupational regulation (licensure compacts, educational requirements, scope of practice), Medicaid, incentive programs, educational expansion, telehealth and more. Even if a state has health workforce data collection initiatives, the information is collected to be profession-specific and is only applicable to a single profession. State governments (both executive and legislative branches) need access to reliable information on single professions. Implementation of the CPMDS tool during the state licensing process will help address state health workforce data needs and ensure consistency and comparability of data.

**Adopting the Cross-Profession Minimum Data Set Tool during State License Renewal**

**Benefits**

- Robust information about your state's workforce
- Allows for balance between collection of profession-specific information and standardization of information available for cross-profession comparison
- Allows for linking to other state data sources
- Is relatively simple administrative implementation when built into electronic license renewal processes

**Challenges**

- Information is comprehensive (and to best inform state planning), requires mandatory participation - and may require authority from legislature
- Buildout of profession—specific data elements


### RESOURCE CONSIDERATIONS

Collecting workforce information in conjunction with licensure processes is a "Best" practice. It is less time consuming, more cost-effective, and provides more comprehensive information than other mechanisms states may use to collect information on the workforce. That being said, it does require resources. The following sections of the document provide a framework for states considering implementation of the CPMDS within licensing processes. As you navigate your way through the roadmap, it will be important to consider, discuss and estimate the resources that would be required for your state and identify where those resources should come from (example: appropriation, administrative sources, etc.)

## RECOMMENDED TRACK

If you are not satisfied with the health workforce information available today in your state, proceed to the next mile marker to learn more about a strategy to collect the specific data needed to support policy and planning within your state.

## FAST TRACK

After completing these activities, if you are satisfied with the health workforce information available for policy and planning within your state, you can take the express lane to Page 20 and learn how these data can be analyzed and used to meet state needs.

MILE 2

# Determine regulatory structure and data collection authorities

## MAXIMIZING THE HEALTH WORKFORCE INFORMATION AVAILABLE TO SUPPORT STATE PLANNING REQUIRES HIGH RESPONSE FROM LICENSED PROFESSIONALS.

Implementation of the CPMDS can be accomplished through a variety of mechanisms. Some states, such as Virginia, have experienced high response rates to voluntary supplemental questions administered to health professionals because the questions are embedded within the licensing process. Other states, such as Indiana, have enacted statutes authorizing the collection of supplemental information at time of license renewal. Many states have pursued the passage of authorizing legislation which would enable the regulatory entity (state board or agency) to collect information directly from health professionals during renewal.

**Data Collection Authority Options for State Governments**

| | Statutory Reference | Executive Branch Action | Summary | State Examples |
|---|---|---|---|---|
| GOOD | ✗ | ✓ Voluntary Response | There is no specific statutory reference to health workforce data collection. However, the executive branch (regulators) assume authority to collect data from licensees under broad statutory language or leverage current processes. | Virginia |
| BETTER | ✓ | ✓ Voluntary Response | Statute provides executive branch regulators with authority to capture data from licensees, but there is language that collection cannot inhibit license renewal (i.e., must be voluntary). | Utah |
| BEST | ✓ | ✓ Mandatory Response | Specific statute enables mandatory reporting from licensees, collected by executive branch regulators.. | Indiana |

WALK

### OPPORTUNITY FOR ACTION

Explore what authority your state has to capture information from health professionals during license renewal through conversations with licensing boards/agency and/or legislators. If appropriate, determine next steps for obtaining the authority needed to collect this information. View examples of states with statutory authority for health workforce data collection.

## WHAT ARE GOVERNING MODELS FOR OCCUPATIONAL REGULATION?

A governing model for occupational regulation is the way in which a state organizes the activities associated with regulating professions. Most states have licensing boards established by the Legislature and appointed by the Governor that perform these functions. However, the authority and responsibilities of licensing boards vary by state. The diagram below demonstrates the breadth of variation in state approaches, outlining which functions are the responsibility of a licensing board and which fall to a more centralized executive branch regulatory agency.

**Fully autonomous/ independent structure for profession-specific boards**

Boards hire their own staff and make administrative, disciplinary, and licensure decisions relatd to the profession

**Centralized agency to support licensing boards/In certain functions (typically through shared administrative infrastructure)**

Boards gernerally have decision-making authority realtd to licensure but the executive branch agnecy (sometimes referred to as an umbrella agency) may be responsible for some decisions, such as budgets, personnel, or investigations.

**Centralized agency with full decision making authority**

An executive branch agency (or director, commission, or council) has full authority over administrative, disciplinary, and lincensure decisions, Profession-specific boards generally still exist but serve only in an advisory capacity.

## HOW DOES A STATE'S GOVERNING MODEL FOR OCCUPATIONAL REGULATION RELATE TO HEALTH WORKFORCE DATA?

Implementing workforce data collection as a part of license application/renewal is seen as a best practice. Occupational regulation structures are important, as it impacts how data collection can be implemented for a profession within a state. For example, within a state with fully autonomous licensing boards, there may be variations in how licensing application and renewals occur between profession types. Conversely, states with centralized licensing agencies generally utilize the same licensing processes and software for multiple profession types. In states where the same licensing processes are utilized for multiple license types, it may be easier and more efficient to develop cross-profession data collection strategies. For states with wide variations in licensing software or processes, a single-profession approach may be more accessible.


### OPPORTUNITY FOR ACTION

Check out Tool B: State Occupational Regulation and Administrative Resources to access a spreadsheet that you can save and complete for your state. This is the first step to understanding how occupational regulation intersects with administrative processes. This will be important as you explore opportunities to enhance the availability of health workforce data.

Relevant source: Council on Licensure, Enforcement and Regulation (CLEAR). Professional and Occupational Regulation: U.S. State Regulatory Structures.

## HOW IS OCCUPATIONAL REGULATION ORGANIZED IN YOUR STATE?

Once authority to collect data has been identified, state regulatory boards/agencies must determine how the data will be collected. This is an important step prior to survey design, as the outcomes of this decision have implications for what functionality may be available. Below is a list of options and considerations for implementation.

### SURVEY ADMINISTRATION OPTIONS

| | | Licensing Software | Cloud-based Survey Tool (such as Qualtrics) | Paper Survey Tool |
|---|---|---|---|---|
| BEST | Within License Application/ Renewal Steps, Before Submitting | ✓ | ✗ | |
| BETTER | Immediately After Application/ Renewal, On Licensing Website | ✓ | ✓ | |
| GOOD | Administered Electronically at Some Other Point in Time, Using Regulatory Contact Info | ✗ | ✓ | |
| GOOD | Administered via Mail at Some Other Point in Time, Using Regulatory Contact Info | ✗ | ✓ | ✓ |

## COMPARING SURVEY ADMINISTRATION OPTIONS

### STATE LICENSING SOFTWARE

**Most states and regulatory entities have adopted electronic processes for licensing (either as 100% adoption or the majority of licenses).** Many questions are asked of licensees during standard regulatory process (such as contact information and disciplinary or legal action). In many instances, licensing software can be modified to include CPMDS questions. In some states, this could be done internally within the executive branch; others rely on software vendors to make changes which may accrue additional cost.

**Licensing software may be limited in terms of functionality when considering using this software for surveying (for example, branching logic and skip patterns are generally not accessible).** However, despite this limitation, surveys can be designed to capture the most applicable information using simple question styles (such as radio buttons, open text fields, and drop-down options). The CPMDS tool was designed using simple question styles to be easily adopted within state licensing software.

**Because data collection during the licensing process would be a state function and would directly support state policy and planning, leveraging state licensing software for survey implementation is considered a best practice.** This approach yields maximum survey response over other methods. Additionally, collecting this data through the regulatory platform communicates the use case directly to the licensee, providing confidence that the information provided will adhere to the same confidentiality and data privacy provisions as other responses within the licensing process.

## EXAMPLE OF APPEARANCE OF LICENSURE SURVEY DURING RENEWAL PROCESS

**Online License Renewal**

### Health Professions Survey

| Question | Answer |
|---|---|
| MENU<br>Demographics<br>Education<br>Employment<br>Finish | |
| 1. What is your sex? | Please Choose |
| 2. What is your race? Mark one or more boxes. | ☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian/Pacific Islander<br>☐ White<br>☐ Some Other Race |
| 3. Are you of Hispanic, Latino/a, or Spanish origin? | Please Choose |
| 4. What is your birth year? | |
| 5. What is your highest level of education? | Please Choose |
| 6. Where did you complete the education program/degree that first qualified you for this license?<br>(Note: for online programs, please select the location where this program was housed) | Please Choose |

MILE 3

# Select the data collection strategy that works for your state

## COMPARING SURVEY ADMINISTRATION OPTIONS

### CLOUD-BASED SURVEY TOOL

**Cloud-based survey tools (such as Qualtrics, RedCap, or Survey Monkey) were created specifically to administer surveys.** The functionality of these tools generally greatly exceeds that of licensing software and of paper surveys, allowing for skip patterns and branching logic so that the respondent only receives the questions that directly pertain to their response.

**Cloud-based surveys can be used in addition to CPMDS questions administered during the licensing process to gather more detailed information from respondents.** For example, a state may implement the CPMDS as "minimum necessary" data elements that are captured during the licensing process. However, there may be specific areas of interest, such as average wages by specialty or geographic region, or understanding issues surrounding provider participation in Medicaid. The state could administer a separate, voluntary cloud-based survey to licensees (either to a subset of licensees based on CPMDS response, or to all licensees) that gathers more specific information on these or other targeted topics of interest. This minimizes burden that additional questions may have on licensees and protects the state from having to modify the CPMDS survey after initial implementation (which may require additional staff or licensing vendor costs), while at the same time ensuring information is available to address targeted issues.

### PAPER SURVEY TOOL

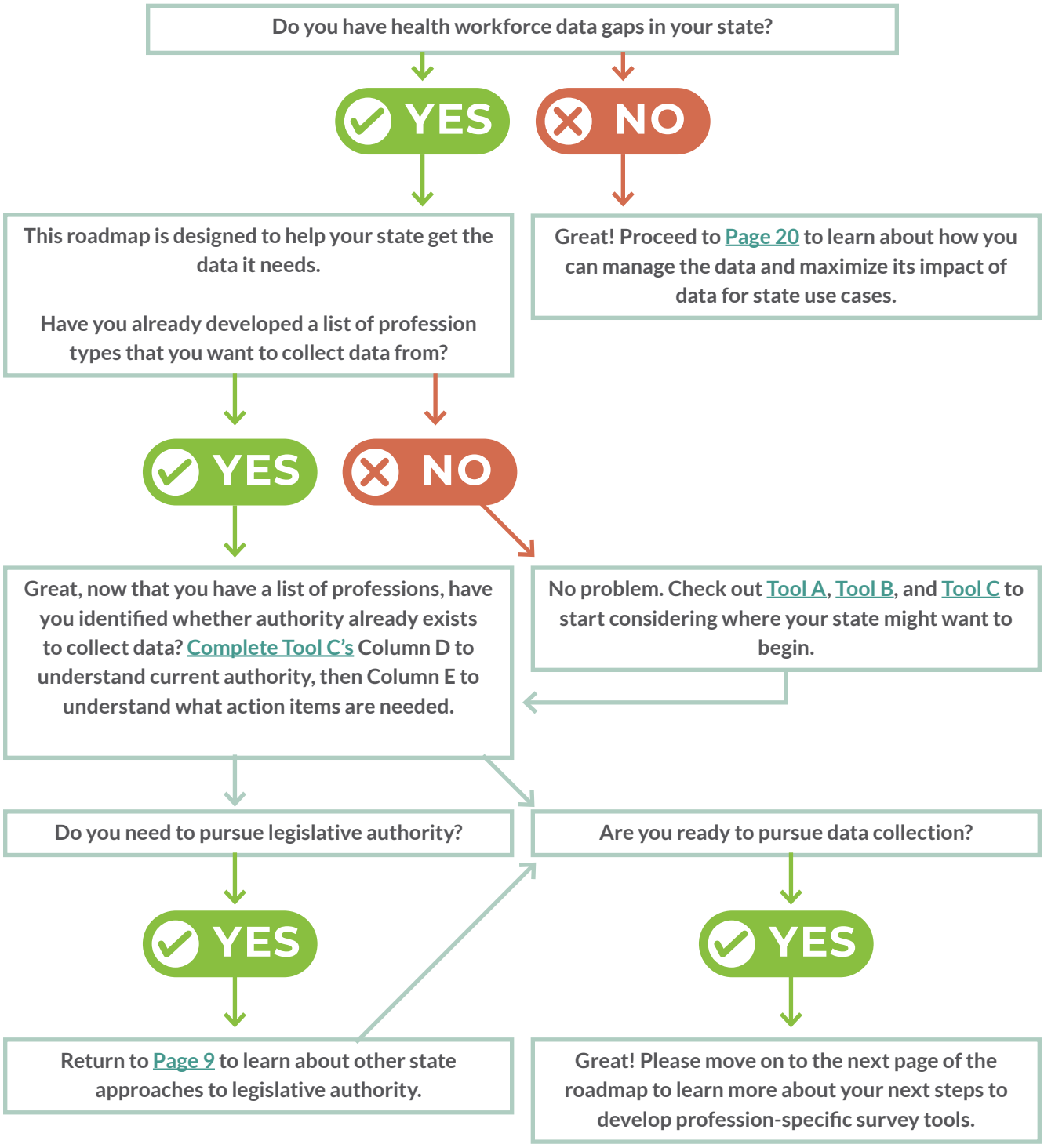
**Although most states have transitioned to electronic licensing, many states still offer a paper option for licensing applications.** In instances where paper applications are permitted, licensure surveys could be provided as a part of the application package to increase response rate (if licensure surveys are only provided electronically, there may be a small subset of licensees that apply or renew on paper who would be excluded from the survey).

**In some states, paper surveys have been utilized outside of the licensing process and on an ad hoc basis.** In general, this occurs when the information is being captured from another party within the state, such as the state Primary Care Office (to support the state's shortage designation processes) or external researchers.

**In general, paper surveys yield low response rates and are not recommended due to a myriad of factors (inaccuracies in mailing address information, administrative burden on licensees, and costs associated with mailing and data entry).**

# DETERMINING THE PATH FORWARD FOR YOUR STATE

## DO YOU HAVE HEALTH WORKFORCE DATA GAPS IN YOUR STATE?



MILE 4

# Finalize CPMDS questions for implementation

## CPMDS: A FRAMEWORK FOR A CUSTOMIZABLE STATE APPROACH

The CPMDS tool was developed to provide structure for common data elements across professions. Although some of the questions were able to be fully standardized across all health profession types, other questions may have standardized question language, but response options may vary slightly or completely across profession types. Below are the three categories of survey questions you may find in the CPMDS.

- Both Question and Response Options are Fully Standardized Across All Professions
  - What: These questions include standardized language for both the question text and response options. These questions and response options are applicable to any and all profession types.
  - Why: Any and all responses to these questions would be comparable.

- Question Text is Standardized; Response Options are Semi-customized for Each Profession
  - What: These questions include 1) standardized language for the question and 2) response option ***categories*** which are common across professions.
  - Why: Semi-customized implementation of response options aligning with common categories will enable cross profession comparisons while providing profession specific information.

- Question Text is Standardized, Response Options are Fully Customized for Each Profession
  - What: These questions include 1) standardized language for the question and 2) fully customized response options by profession.
  - Why: A common question format would ensure that future within-profession comparisons are supported regardless of the various response options.

| Question Style | Count of Data Fields |
|---|---|
| Both Question and Response Options are Fully Standardized Across All Professions | **6** + 2 supplemental |
| Question Text is Standardized; Response Options are Semi-customized for Each Profession | **6** + 1 supplemental |
| Question Text is Standardized, Response Options are Fully Customized for Each Profession | **4** +2 supplemental |

WALK

### OPPORTUNITY FOR ACTION

As you are working through this step, check out the CPMDS and the associated CPMDS FAQ document.

## QUICK IMPLEMENTATION: JUMPSTARTING DATA COLLECTION USING STANDARDIZED QUESTIONS

Although the CPMDS tool was developed to support customization, many of the key data elements were developed to capture some of the most basic and critical data elements in a standard fashion from all health profession types. If customization of certain data elements (through the development of profession-specific survey tools) is too heavy of a lift, a state could begin by implementing six of the data elements as is. These six data elements have both standardized questions and standardized response options across all health professions.

Additionally, although customization would provide greater granularity to the six questions with semi-customizable response options, those questions could also be implemented as is.

### WHICH CPMDS DATA ELEMENTS HAVE FULLY STANDARDIZED QUESTIONS AND RESPONSES?

- Sex
- Race/Ethnicity
- Age/Year of Birth
- Telehealth
- Hours/Week
- Hours/Week in Direct Patient Care

**Optional Supplemental Questions**

- Gender
- Year Completed Education

# DEVELOPING PROFESSION-SPECIFIC TOOLS— BEGINNING WITH CUSTOMIZABLE RESPONSES

For the questions that have semi-customizable or fully customizable response options, there is an opportunity to develop response options that suit state needs.

## QUESTIONS WITH SEMI-CUSTOMIZABLE RESPONSE OPTIONS

Education level is an example of a data element that could have semi-customized responses. There are standardized categories of education level presented within the CPMDS. However, not all categories would apply for all profession types. Additionally, it may be appropriate to obtain an additional level of detail on education categories for certain profession types.

### WHICH CPMDS DATA ELEMENTS HAVE SEMI-CUSTOMIZED RESPONSES?

- Highest Level of Education
- Where Completed Education
- Employment Status
- Future Employment Plans
- Employment Type/Arrangement
- Position Type/Role

**Optional Supplemental Questions**

- Qualifying Education

### NO RESOURCES? NO WORRY.

If developing profession-specific tools is too heavy of a lift, a state could begin by implementing 12 of the questions as is (those with standard responses or flexible responses). Although not customized to the profession, responses to these questions as is would provide a baseline level of information to support planning.

Below is the current CPMDS question for education, and some considerations for state implementation.

### CPMDS QUESTION:

What is your highest level of education?
SINGLE SELECT

- High school diploma (or equivalency)
- Some college, no degree
- Technical/Vocational Certificate
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Post-graduate training
- Professional/Doctorate Degree
- Postdoctoral training

EXAMPLES

- It would be inappropriate to include "high school diploma" as an option for "highest education" for professions whose minimum education for profession entry includes post-secondary education, such as peer support workers. Conversely, it may not be appropriate to include "high school diploma" (or responses A-G) for a medical license.
- A profession may desire to track specific educational options within a given category. For example, instead of simply including "Professional/Doctorate Degree," Medicine may be interested in replacing this response option with "Doctor of Medicine (MD)" or "Doctor of Osteopathic Medicine (DO)." Both of these response options would be mappable to (and fall under the common category of) "Professional/doctorate degree," but may provide greater granularity for state planning.

# QUESTIONS WITH FULLY CUSTOMIZABLE RESPONSE OPTIONS

Specialty is an example of a data element that varies widely between profession types. Specialty (which is sometimes referred to as "field" or "area of practice" by some professions) is a critical data element for all health professions. However, due to wide variations, it is not possible to standardize response options across all health profession types.

Below is the current CPMDS question for specialty, and some considerations for state implementation.

### CPMDS QUESTION:

A. Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?"
SINGLE RESPONSE
[FLEXIBLE RESPONSE OPTIONS BY PROFESSION]

### WHICH DATA ELEMENTS HAVE FULLY CUSTOMIZED RESPONSES?

- State/Jurisdiction of Licensure
- Specialty
- Practice Location (State and Zip)
- Setting Type
- (Optional Supplemental Question) Practice Location (Street Address and City)
- Patient Panel Characteristics

EXAMPLES:

- The specialty options for physicians will vary widely from the specialty options for dentists. A profession-specific lens will be critical to ensure the options provided for specialty (and other data fields within this category) are appropriate.

CONSIDERATIONS:

- There may be instances where the response options developed for these fields could cut across various profession types. For example, it may be appropriate to align most of the specialty and setting response options for dentists and dental hygienists. Similarly, it may be appropriate to align physician assistant and advanced practice registered nurses for some fields.
- State data needs should drive the response options included. This will be of utmost importance for profession types that are included in state health professional shortage area designation activities. The specialties and settings must align with federal criteria in order for your state to use these data to qualify for those opportunities. Your state primary care office can provide insight on those specific data needs.

## CUSTOMIZING RESPONSE OPTIONS AND CONSIDERING ADDITIONAL AREAS OF INTEREST

If a state is interested in developing profession-specific surveys using the CPMDS framework, there are various considerations that should be taken into account during the development process.

### 1 REVIEW PROFESSION-SPECIFIC SURVEY TOOLS THAT HAVE ALREADY BEEN DEVELOPED.

Many resources exist that contain profession-specific data elements. A review of existing surveys can provide direction and insight as to which response options could be included. Profession-specific workforce surveys may exist through HRSA, professional trade associations, or regulatory associations. A reference guide for previous profession-specific data efforts can be found in Supplemental Resources: National Health Workforce Data Sources

### 2 IDENTIFY SPECIFIC STATE DATA NEEDS TO ENSURE ALIGNMENT WITH RESPONSE OPTIONS.

There are likely a number of initiatives within a state/jurisdiction that would benefit from workforce data. During the profession-specific survey development and finalization process, identification of those initiatives and consultation with points of contact will ensure the response options align with information necessary to support state activities. Tool D: State Health Workforce Data Needs contains a list of common state initiatives related to the health workforce and corresponding state government perspectives.

### 3 CONSIDER ADDITIONAL QUESTIONS, AND APPROPRIATENESS OF INTEGRATION OF THESE QUESTIONS, WITHIN REGULATORY SURVEY OR THROUGH ALTERNATIVE DATA COLLECTION MECHANISMS.

The CPMDS has been designed to support collection of the minimum necessary information to support state planning for the health workforce. Questions seeking to collect additional information of interest should be carefully considered prior to incorporation into profession specific tools. For example, a state agency, such as Medicaid, may recommend including additional questions about Medicaid participation to support targeted assessments and planning. Additional data elements could be included within the state profession surveys, or could be included in a separate supplemental survey administered to the workforce. Trade-offs such as survey length, response rate, and intended audience should be considered.

### 4 CONSULT THE EXPERTS.

In addition to consulting state personnel to provide input on profession-specific data elements, external stakeholders can also serve as profession subject matter experts. These individuals could be consulted to review and provide input on response options. A list of these external perspectives is also presented within Tool E: Stakeholder Inventory for consideration.

MILE 5

# Secure and deploy the resources needed to store, manage, and analyze the data

## ONCE YOU HAVE STATE HEALTH WORKFORCE DATA, WHAT DO YOU DO WITH IT?

Health workforce information is captured during the regulatory process. It is generally stored under the same parameters as regulatory data: within a database that is commonly used for compliance purposes only. In order to prepare the health workforce data for state use, three key data principles must be incorporated:

| Data Storage: Building a State Health Workforce Data Library | Data Management: Transforming raw workforce data into usable information | Data Analysis: Putting workforce data into action |
|---|---|---|
| Data are initially stored alongside broader regulatory data, but can also be incorporated within other data storage initiatives to enhance access and use. States may develop and/or contract the development of a longitudinal database to store cycles of health workforce data: A state health workforce data library. | Data must be transformed from raw format into usable and accessible data tables. Data management processes generally include cleaning, coding, and storing data in an accessible format. This step may require a database engineer or data analyst. | The data are ready to be used! In order to use the data to answer questions, support assessment, and inform policy and programming, a capacity for data analysis and reporting is required, and may include data visualization expertise. This step requires "business analytics" to help bridge the gap between the data and the analysis. |

### WHAT RESOURCES AND PERSONNEL ARE REQUIRED?

| Data Storage | Data Management | Data Analysis |
|---|---|---|
| • Database (cloud-based or in-house server)<br>• Compliance with data privacy provisions<br>• Personnel with database skills (database engineer, architect, or administrator) | • Data governance<br>• Data codebooks<br>• Health Professions Surveys<br>• Geocoding software (examples: ArcGIS or Melissa)<br>• Personnel: Data Analyst or Engineer | • Statistical software (examples: SAS, SPSS, Tableau, Power BI)<br>• Personnel: Business Analyst, Data Analyst, Data Coordinator<br>• Qualitative data analysis through natural language processing capacity (such as NVivo) |
| **Financial resources are likely required to support each of these major activities. Cybersecurity and data privacy measures should be taken into account to ensure data protection.** | | |

Resource: Collaborating With Licensing Bodies in Support of Health Workforce Data Collection: Issues and Strategies. 2016.

# HOW DO OTHER STATES MANAGE HEALTH WORKFORCE DATA?

States vary significantly in their implementation of data-related activities. Review the implementation options below to consider what might make sense in your state.

## MODEL A: DEVELOPING STATE GOVERNMENT-BASED HEALTH WORKFORCE INFORMATION CENTER

Data-related activities require significant data expertise. Some states have developed an internal expertise. For states that have pursued this model, this center may be housed within a department of health (a common superuser of workforce data due to primary care office activities associated with health professional shortage area designation activities) or regulatory agency (generally where the data originates, through the licensing process).

STATE EXAMPLES:

- Minnesota Health Workforce Planning and Analysis Unit, housed within the Minnesota Department of Health
- Texas Health Professions Resource Center, housed within the Texas Department of State Health Services
- Virginia Healthcare Workforce Data Center, housed within the Virginia Department of Health Professions

INSIDER TIPS:

- Most states have an Area Health Education Center (AHEC). In some states, the AHEC receives state funding support. The AHEC may be an untapped health workforce data powerhouse, like it is in South Carolina.
- Many states have developed a cross-governmental center to manage state data. Are there any opportunities to leverage this data expertise to tackle health workforce issues?

## MODEL B: PARTNERING WITH EXTERNAL EXPERTISE TO SUPPORT STATE GOVERNMENT

Internal data expertise may not be available within your state. Many states have developed strategic partnerships with external entities to provide this data support. A memorandum of understanding and data use agreement can ensure the state's goals are met.

- Indiana Bowen Center for Health Workforce Research and Policy, housed within the Indiana University School of Medicine
- Sheps Health Workforce NC, housed within the University of North Carolina Chapel Hill

If a multi-profession approach feels overwhelming, consider starting with a single profession. The Illinois Nursing Workforce Center is a state initiative focused exclusively on workforce data and initiatives for LPNs, RNs, and APRNs.


### OPPORTUNITY FOR ACTION

Wondering which model might make the most sense for your state? Consider what strategic strengths your state possesses. Are there any state agencies that could take on health workforce data? Any opportunities for strategic partnerships with external entities?

MILE 6

# Transform the data into actionable information using collaboration to maximize impact

## HEALTH WORKFORCE DATA REPORTING FORMATS

There are several common formats that health workforce data may take to support assessment, planning, and policy development. In order to make the greatest impact, the data has to be presented in a format that connects with the intended audience. Below are some examples of data outputs and potential corresponding use cases.

| Reporting Format | Use Case |
|---|---|
| **Data Files**  | Data file transfers support states' HPSA processes. This format is also beneficial when the data question results in a list of professionals that meet certain criteria. |
| **Data tables and charts**  | This is a common data product with a variety of potential use cases. This format can be useful for presentation, reports, grant applications, and assessment. |
| **Maps**  | Depict workforce distribution across state or within specific geographies. When coupled with population data, population to provider ratios can be presented and may be useful for identifying shortages. |
| **Infographics and Visualizations**  | Accessible and engaging graphics that present the data in ways that are easy to understand. This format may be useful for marketing campaigns, briefs, and other materials focused on reaching broad audiences. |

### IN ADDITION TO ANSWERING AD HOC QUESTIONS RELATED TO THE HEALTH WORKFORCE, THESE DATA CAN BE USED FOR CROSS-GOVERNMENTAL STATE PLANNING.

Many states have strategies in place to support state health workforce policy coordination, or the use of data to support state health workforce planning. The way in which states formalize these strategies varies but may include: a dedicated state health workforce entity (such a center, office, commission, or council), funding to support coordination activities, or a formal charge through state statute or rules. States that have developed this capacity generally have supported such activities through leadership of a state agency, which is done by the agency directly or in partnership with an external entity.

## HEALTH & HUMAN SERVICES

Definition: States have a significant role in health and human service functions, such as administration of Medicaid and other public sector programs, public health activities, health facility regulation, and more. States vary significantly in how health and human service activities are distributed into executive branch agencies (ex: one agency that offers all health/human service activities, or two or more agencies that fulfill distinct services). Among the states with formalized health workforce policy coordination strategies, health or human service agencies most frequently lead coordination efforts.

### BENEFITS TO THIS APPROACH:

- Under this strategy, population health is front and center.
- These agencies are commonly responsible for supporting state Health Workforce Shortage Area designation activities, which may ensure that any policy work done within this agency has a natural connection and foundation of health workforce data.
- If a state has state-based health workforce incentive programming, such as scholarships or loan repayment, these activities are generally housed under health and human services or public health agencies. As such, broader policy coordination activities established through formal mechanisms is a natural alignment.
- Many health care delivery and regulatory activities are within the purview of health and human services or public health agencies, including Medicaid programming, public health activities, health facility/provider licensing, and population- or program-specific initiatives such as behavioral health or long-term care.

### CONSIDERATIONS:

- Health and human services agencies are frequently responsible for administration of a number of policies and programs. Care must be taken to ensure the coordination is properly valued and resourced and not lost in other initiatives.

**STATE EXAMPLE:**

Georgia Board of Health Care Workforce

## LABOR/WORKFORCE DEVELOPMENT

**Definition:** States are responsible for state workforce development activities, including directing pass-through funding to support these activities and developing a state workforce plan. Some states have aligned their health workforce policy coordination activities with broader state workforce development activities to bring a labor-specific lens and see health as a workforce development industry.

### BENEFITS TO THIS APPROACH:

- States are responsible with creating a state workforce plan. States with a labor/workforce development perspective leading health workforce policy coordination activities are well-positioned to contribute to the health industry section of the state workforce plan.
- The Bureau of Labor Statistics has well-established processes for supply and demand data by occupation and by industry classification. Alignment with labor/workforce development provides states with a solid data foundation to initiate health workforce policy coordination conversations and validate or provide contextual information on data findings.
- Labor/workforce development strategies (earn-and-learn programming, registered apprenticeships, upskilling, industry credentials, etc.) have historically been siloed from traditional health workforce development strategies (such as loan repayment, scholarships, regulatory policy change, etc.). States with a labor/workforce development perspective leading health workforce conversations adds new strategies to historical health workforce development strategies.

### CONSIDERATIONS:

- Generally, workforce development conversations prioritize high-wage, high-demand jobs with minimal entry requirements. Although these jobs do exist in the health sector (ex. Dental assistant, dental hygienist, registered nurses), there are a number of other health occupations that fall outside of these criteria. For example, some health occupations may be high-demand, lower-wage (but critically important to population health activities), such as certified nurse aides and home health aides. Other jobs may be high-wage, high-demand, but have significant education and training requirements, such as physicians, physician assistants, and behavioral health counselors. Alignment of health workforce policy coordination activities with labor/workforce development perspective, may be helpful to identify and meet the workforce needs of the state.

STATE EXAMPLE:

Washington Health Workforce Council

## OCCUPATIONAL REGULATION/LICENSING

**Definition:** States serve a major role in occupational regulation of the health workforce. State entities responsible for health workforce occupational regulation may serve a leading role in a state's coordination of health workforce policy and programming.

### BENEFITS TO THIS APPROACH:

- States have a major role in determining entry (prohibitions, education/training, examinations, etc.) and practice (services that can be provided and those that cannot, supervision or oversight, etc.) policies.
- Policy coordination strategies that include multiple perspectives (and represent multiple occupations) could neutralize challenging profession-specific policy discussions.

### CONSIDERATIONS:

- States vary significantly on how occupational regulation is structured, from a centralized agency that oversees and implements all regulatory activities to a decentralized approach which relies on independent occupational boards to conduct regulatory activities. State structuring of health workforce occupational regulation should be taken into account when determining feasibility of this approach.
- Although significant, health professions' occupational regulation is only one of the many policies related to the health workforce. Alignment with occupational regulatory entities may limit policy coordination in other spaces (ex: Medicaid, health professional shortage area activities, workforce development, etc.).

**STATE EXAMPLE:**

Virginia Board of Health Professions


### OPPORTUNITY FOR ACTION

Thinking about what might make sense for your state? Start by making a list of the key stakeholders in your state who might provide insights into current initiatives or strategic opportunities using the Tool E: Stakeholder Inventory Tool. As a bonus, these might be the same individuals who could sit on such a coordinating body and provide direction.

HRRI
Healthcare Regulatory Research Institute

# FAQs: CROSS-PROFESSION MINIMUM DATA SET (CPMDS)

WITH OPTIONAL SUPPLEMENTAL QUESTIONS

VERITAS HEALTH SOLUTIONS

The following organizations participated in the development of this tool:







Funding for this project was provided by the Healthcare Regulatory Research Institute.

# Table of Contents

# Cross Profession Minimum Data Set and Supplement

The purpose of the CPMDS is to serve as an aligning framework for states, organizations, and researchers seeking to collect workforce information from healthcare professionals. The following questions are considered "minimum necessary." Broad adoption of the CPMDS will support a level of standardization across healthcare workforce data sources, enabling comparisons across jurisdictions, supporting research, and facilitating potential future data integration and aggregation initiatives. The following section has been designed to support entities considering implementation of the CPMDS, outlining the research behind and rationale for CPMDS questions.

# Demographics

## Why is demographic data included in the CPMDS?

Demographics typically include information such as age, sex, gender, race, and ethnicity. Demographic information provides important insights into the characteristics of people, groups, and populations. Demographic data are collected by government entities, such as the United State Census Bureau, for the purpose of understanding population characteristics. Prior to the development of the CPMDS, no cross-profession strategy to support the consistent collection of demographic data for the health workforce has existed.

## Where did these questions come from?

Demographic questions in the CPMDS are considered the "minimum necessary" to support a basic understanding of the demographics of the workforce and enable comparisons to the population. The CPMDS questions align with the United State Census.

## Do I need to implement these demographic questions?

Where demographic data consistent with the CPMDS already exist and are easily accessible within administrative systems, these questions are not advised for implementation. Rather, demographic data should be linked to data collected through the CPMDS to support workforce analyses.

## What about gender?

It is important to recognize that these questions are not inclusive of all demographic characteristics of people and populations. The U.S. Census currently captures sex and not gender of individual respondents. In order to maximize comparability of questions across information sources, it is recommended that the Cross-Professional MDS tool include a question capturing the sex of an individual. Gender may be considered "minimum necessary" by some entities and prioritized by a state/professional/organization that implements the CPMDS. An optional Gender question is provided to supplement the basic CPMDS questions.

## Why are Race and Ethnicity separate questions?

Race and Ethnicity are separate demographic characteristics and should be assessed separately to ensure individuals provide a response to each category.

## Why is the year of birth included in the CPMDS?

Average workforce age is important for informing projections. Recognizing that date-of-birth is personally identifiable and a static reporting of age may not be useful, it is recommended that year of birth be included to

enable an estimate of age. In the instance that the implementing state/entity already maintains date-of-birth in administrative data and it is able to be linked to a respondent, this question would not need to be implemented.

## Demographic Questions

### Sex (Standard question, Standard Response)

What is your sex?
SINGLE-SELECT

A. Male
B. Female

### Optional: Gender (Standard question, Standard Response)

What is your gender?

A. Male
B. Female
C. Transgender
D. Gender Non-binary
E. Other
F. Prefer not to answer

### Race/Ethnicity (Standard question, Standard response)

What is your race? Mark one or more boxes.
MULTI-SELECT

A. American Indian or Alaska Native
B. Asian
C. Black or African American
D. Native Hawaiian/Pacific Islander
E. White
F. Some Other Race

Are you of Hispanic, Latino/a, or Spanish origin?
SINGLE-SELECT

A. No
B. Yes

### Age/Year of Birth (Standard question, Standard response)

What is your birth year?

OPEN FIELD

# Education

## Why are education questions included in the CPMDS?

Health professions generally have specific educational requirements that must be fulfilled in order to enter into practice. Basic information on the educational characteristics of health professionals supports targeted assessment of the training pathways.

## Do I need to collect these educational characteristics?

Some states/entities may already maintain education information in administrative data systems, such as regulatory entities, which may collect educational information as part of license application requirements. In the instance that these data are readily available and able to be linked to an individual's data collected through the CPMDS, these questions should not be implemented.

## Why does the CPMDS include a question regarding where someone completed their education?

When combined with information on current practice characteristics, where a professional completed their training provides important insights into the mobility of the workforce.

## What about the specific training program or institutions where health professionals completed their training?

In order to maximize comparability and minimize the length of a survey tool, it is recommended that any questions relating to the specific school/institution where training was completed be added on an as-needed basis. Collection of any program-level information should be implemented in a manner mappable to a state/country.

## Why is qualifying education included in the CPMDS as optional?

Qualifying education is valuable to assess the level of educational preparation of individuals at the time of their entry into a respective profession. This question is indicated as optional because it may not be applicable for all professions. It is useful for professions that offer multiple pathways for qualifying education (e.g., nursing and dental hygiene). This question offers mappable response options that can be customized for implementation to meet the unique needs of a respective profession.

## Why is the highest level of education included in the CPMDS as optional?

The highest education is valuable to assessing the level of educational preparation/achievement of individuals within certain professions. This question is indicated as optional because it may not be applicable to all professions. It may be especially useful for professions for whom national benchmarks have been established related to educational attainment (e.g., nursing, physical therapy, pharmacy). This question offers mappable response options that can be customized for implementation to meet the unique needs of a respective profession.

## Education Questions

**Where Completed Education (Standard question, Mappable response)**

Where did you complete the education program/degree that first qualified you for this license? (Note: for online programs, please select the location where this program was housed.)
SINGLE-SELECT

A. [LIST OF U.S. STATES and territories]
B. Another Country (not U.S.)

**(Optional) Qualifying Education (Standard question, Mappable response)**

What type of degree/credential first qualified you for this license?
SINGLE-SELECT

a. High school diploma (or equivalency)
b. Some college, no degree
c. Technical/Vocational Certificate
d. Associate Degree
e. Bachelor's Degree
f. Master's Degree
g. Post-graduate training
h. Professional/Doctorate Degree
i. Postdoctoral training

**(Optional) Year Completed Education (Standard question, Standard response)**

What year did you complete the education program/degree that first qualified you for this license?
OPEN FIELD

**(Optional) Highest Level of Education (Standard question, Mappable response)**

What is your highest level of education?
SINGLE-SELECT

A. High school diploma (or equivalency)
B. Some college, no degree
C. Technical/Vocational Certificate
D. Associate Degree

E. Bachelor's Degree
F. Master's Degree
G. Post-graduate training
H. Professional/Doctorate Degree
I. Postdoctoral training

# Licensure/Regulatory

## Why is a question regarding states/jurisdictions of licensure included in the CPMDS?

Some health professionals may be licensed in multiple states/jurisdictions. Understanding whether, to what extent, and where health professionals hold licensure may be helpful in understanding interstate mobility.

### Implementation consideration for states/jurisdictions of licensure:

Response options may be modified based on a profession's unique practice authorities (such as compact or practice privilege).

## Licensure/Regulatory Question

**State(s)/Jurisdictions(s) of Licensure (Standard question, Flexible response)**

In what state(s) and/or jurisdiction(s) do you hold an active license or have authority to practice? (Select all that apply.)
MULTI-SELECT
[LIST OF U.S. STATES and territories]
(OPTIONAL)

# Employment/Labor Market

## Why are employment/labor market questions included in the CPMDS?

The current employment status and future employment plans of health professionals are foundational to understanding current healthcare capacity, refining workforce projections, and planning for the future. These questions are important to supplement labor data reported by the U.S. Bureau of Labor Statistics.

## Why is employment status included in the CPMDS?

Employment status is an important labor market indicator. In addition to providing insight into whether an individual is currently employed, the proposed question also provides insight into whether a health professional is currently engaged in a position that requires their license. This is useful for identifying licensed health professionals that may not be currently practicing or employed.

### Implementation considerations for employment status:

Additional information regarding workforce capacity may be collected by expanding response options. For example, "not currently working" may be expanded to include options such as "Not working but seeking employment in the field of [PROFESSION]" or "Not working and not seeking work in the field of [PROFESSION]."

## Why are future employment plans included in the CPMDS?

A future employment plan is an important labor market indicator that may be useful to inform workforce projections for a given period of time.

### Implementation consideration for future employment plans:

Response options relating to increasing or reducing hours may be expanded and/or customized to meet specific data needs (e.g., hours in direct patient care versus non-patient care hours).

## Employment/Labor Market Questions

Employment Status (Standard question, Mappable response)

What is your employment status?
SINGLE-SELECT

A. Actively working in a position that requires this license
B. Actively working in a position in the field of [PROFESSION] that does not require this license
C. Actively working in a position in a field other than [PROFESSION]
D. Not currently working

E. Retired

### Future Employment Plans (Standard question, Mappable response)

What best describes your employment plans for the next two years?
SINGLE-SELECT

A. Increase hours in a field related to this license
F. Decrease hours in a field related to this license
G. Seek employment in a field unrelated to this license
H. Retire
I. Continue as you are
J. Unknown

# Professional/Practice Characteristics

## Why are professional characteristics included in the CPMDS?

Professional characteristics, such as specialty, practice locations, hours per week, etc., provide information that is critical to understanding the workforce capacity that is available to provide certain types of healthcare services in certain locations. These questions are useful to support the identification of workforce shortages, including federal designations such as health professional shortage areas (HPSAs) and medically underserved areas/populations (MUA/P).

## Why is specialty included in the CPMDS?

In addition to the training required for entry into a health profession, many health professionals complete additional training and/or certification in order to obtain additional expertise in specific areas/fields. The term specialty is typically used to identify additional training/expertise (e.g., family medicine, pediatrics, cardiology, substance use disorder treatment, etc.). Professionals are licensed for a specific health profession/occupation. In most instances, additional state licenses are not issued for specialties within a profession/occupation (e.g., individuals are licensed by states as physicians, not obstetricians).

### Implementation consideration for specialty:

Specialty is a data field that varies widely between health professions. It is important that specialty/field/area of practice is captured from all health profession types, but due to wide variations, it is not possible to standardize response options. For health professions where similarities in specialty types exist, it may be helpful to consider alignment in response options to the extent possible (e.g., states may be interested in monitoring primary care capacity among physicians, advanced practice registered nurses, physician assistants, and others).

## Why is telehealth included in the CPMDS?

The rapid adoption of telehealth over the past decade, especially since 2020, and state implementation of regulatory policies aimed at enhancing interstate mobility of the workforce (licensure compacts, reciprocity agreements, mutual recognition), have implications for tracking and monitoring the health workforce. This question has been added to enable the monitoring of telehealth participation among health professionals. The definition of telehealth used in this question was sourced from a CMS Telehealth Toolkit.

## Why is practice location included in the CPMDS?

The location a health professional practices in may or may not be the same as the location associated with their license. Practice location information is needed in order to determine the capacity of health professionals within certain communities/geographies.

## Why are there four separate questions for practice location?

The level of information required to support workforce assessments and planning may vary. In the case of professions for whom federal workforce shortage designations exist (e.g., physicians, dentists, psychologists, and mental health counselors), states require a street address, city, state, and zip code to verify and or update practice address information in the federal system. This level of information may not be required for other types of workforce assessments. For example, the zip code of practice and/or county of practice may be sufficient to support assessment and planning for other professions.

### Implementation considerations for practice locations:

It is important to note that street address level information is required by states in order to determine federal health professional shortage area designation status. Some health professionals practice at more than one location. Practice location questions may be repeated for up to three practice locations.

## Why is employment arrangement/type included in the CPMDS as a professional characteristic?

The employment arrangements/types of health professionals may vary by profession, setting, etc., or personal preference. The structure of employment (e.g., employed versus temporary employment/locum tenens) has implications for workforce assessments and federal shortage designations.

## Why is position type/role included in the CPMDS?

Health professionals may be employed/work in various roles within or outside of patient care. Having information on position type/role is useful for workforce assessment and planning across various sectors and settings related to the health workforce. For example, information on health professionals in faculty/educator roles can support related workforce assessments and planning for education program expansion. This question also provides insight into whether health professionals are contributing to healthcare capacity through clinical practice or whether they are contributing to other areas.

### Implementation consideration for position type/role:

The CPMDS question is focused on capturing a health professional's primary practice type/role. Many health professionals may serve in multiple roles. Additional questions could be added to capture role/title for professionals that split their time between multiple.

## Why is the setting type included in the CPMDS?

Health professionals may be employed at/practice in many settings. The specific types of settings vary widely by profession. Practice setting provides insight into where workforce capacity is currently distributed across

the health system. It is important to note that setting is also required for states to identify as part of federal workforce shortage designations, where only "community based" health professionals are included in workforce capacity assessment.

### Implementation consideration for practice setting:

It is important that setting is captured from all health profession types, but due to wide variations, it is not possible to standardize response options. It is recommended that "Telehealth" be included as a setting option.

## Why are hours per week included in the CPMDS?

Hours per week is useful to estimate a health professional's full-time equivalency. Full-time equivalent or FTE refers to the number of hours considered full-time. Generally, 40 hours is considered to be equivalent to 1 FTE. The hours per week question and response options are designed to standardize FTE estimates.

## Why does the CPMDS include a question for hours per week and another question for hours per week in direct patient care?

Hours per week in direct patient care provides insight into clinical care capacity, whereas hours per week includes both patient care and other roles and responsibilities. Hours per week in direct patient care is the metric required for federal health workforce shortage designations.

### Implementation consideration for hours per week/hours in direct patient care per week:

Although more specificity (specific hours) may seem desirable, open text fields require significant resources for data preparation and may not result in consistent and comparable information. The proposed categories enable estimates of full-time equivalents and align with data needs of states for federal health professional shortage area designations.

## Professional/Practice Questions

Specialty (Standard question, Flexible response)

Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?
SINGLE RESPONSE
[FLEXIBLE RESPONSE OPTIONS BY PROFESSION]

Telehealth (Standard question, Standard response)

Telehealth may be defined as the use of electronic information and telecommunications technologies to extend care to patients, and may include videoconferencing, store-and-forward imaging, streaming media, and terrestrial and wireless communications. Do you use telehealth to deliver services to patients?

SINGLE-SELECT

A. No
B. Yes

### Practice Location (Standard question, Flexible response)

(Optional) What is the street address of your primary practice location? If this does not apply, please indicate "N/A."
OPEN TEXT FIELD

(Optional) In what city is your primary practice located? If this does not apply, please indicate "N/A"

OPEN TEXT FIELD

In what state is your primary practice location? If this does not apply, please select "N/A"
[LIST OF U.S. STATES AND TERRITORIES AND OPTION FOR N/A]

What is the five-digit zip code of your primary practice location? If this does not apply, please indicate "N/A"
OPEN TEXT FIELD

### Employment Type/Arrangement (Standard question, Mappable response)

Which of the following best describes your current employment arrangement at your principal practice location?
MULTI-SELECT

A. Self-employed/Consultant
B. Salaried employee
C. Hourly employee
D. Temporary employment / Locum tenens
E. Other
F. Not Applicable

### Position Type/Role (Standard question, Mappable response)

Please identify the role/title(s) that most closely correspond(s) to your primary employment/practice type.
MULTI-SELECT

A. Administrator
B. Clinical Practice
C. Faculty/Educator
D. Researcher
E. Other
F. Not Applicable

### Setting Type (Standard question, Flexible response)

Which of the following best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable." SINGLE-SELECT
[FLEXIBLE RESPONSE OPTIONS BY PROFESSION]

A. Telehealth

B. Not applicable

### Hours/Week (Standard question, Standard response)

Estimate the average number of hours per week spent at your primary practice location. If this does not apply, please select "not applicable."
SINGLE-SELECT

A. 0 hours per week/Not applicable
B. 1 – 4 hours per week
C. 5 – 8 hours per week
D. 9 – 12 hours per week
E. 13 – 16 hours per week
F. 17 – 20 hours per week
G. 21 – 24 hours per week
H. 25 – 28 hours per week
I. 29 – 32 hours per week
J. 33 – 36 hours per week
K. 37 – 40 hours per week
L. 41 or more hours per week

### Hours/Week in Direct Patient Care (Standard question, Standard response)

Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your primary practice location. If this does not apply, please select "not applicable."
SINGLE-SELECT

A. 0 hours per week/Not applicable
B. 1 – 4 hours per week
C. 5 – 8 hours per week
D. 9 – 12 hours per week
E. 13 – 16 hours per week
F. 17 – 20 hours per week
G. 21 – 24 hours per week
H. 25 – 28 hours per week
I. 29 – 32 hours per week
J. 33 – 36 hours per week
K. 37 – 40 hours per week
L. 41 or more hours per week

### (Optional) Patient Panel Characteristics (Standard question, Flexible response)

Please indicate the population groups to which you provide services. Please check all that apply.
MULTI-SELECT CHECKBOXES

A. Newborns
B. Children (ages 2-10)
C. Adolescents (ages 11-19)
D. Adults
E. Geriatrics (ages 65+)

F. Pregnant women
G. Veterans
H. Incarcerated individuals
I. Individuals with disabilities
J. Individuals who speak a language other than English
K. Medicaid
L. Medicare
M. Sliding Fee Scale
N. None of the above

**Why We Can't Count Our Doctors (And How To Fix It)**

Hannah Maxey and Courtney Medlock

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Imagine trying to run a Fortune 500 company without knowing how many employees you have, where they work, or what skills they possess. This is exactly how the US manages its health care workforce—with fragmented, incomplete data that leaves federal and state policy makers unable to answer basic questions about who provides care and where.

This isn't just an administrative inconvenience. The federal government has held hearings on the topic, and the Centers for Medicare and Medicaid Services (CMS) has issued requests for information to address health workforce data gaps. More than 28 states have prioritized improving workforce data to guide state planning efforts by leveraging licensing processes. National organizations including the National Governors Association, the National Conference of State Legislatures, and the Council of State Governments are developing resources to support workforce data improvement.

Yet, a recurring theme persists: The inability to answer fundamental questions about the health care workforce, especially at the state and local level, has real consequences for millions of Americans.

**The Stakes For Health Care Access And Policy**

Poor workforce data and uninformed planning directly affect health care access for millions of Americans. Patients in rural areas drive hours to access specialists due to unidentified local shortages. Students exploring health care careers lack guidance about in-demand roles and geographic opportunities. Federal and state workforce development investments risk missing their targets without accurate targeting data.

These inefficiencies ultimately burden Americans financially, driving up costs for individuals and the health care system. When viewed through the lens of organizational management, these failures highlight the risks of mismanaging human capital in a sector where such mismanagement directly impacts health outcomes.

**The Patchwork Problem**

Multiple sources of workforce data exist, but none provide a complete picture. Federal sources such as the Bureau of Labor Statistics, Health Resources and Services Administration, and CMS offer broad overviews but lack the granularity needed for targeted and local planning. Administrative sources such as claims data and electronic health records are detailed but don't consistently include critical workforce information.

Professional association data, while detailed, is often proprietary and limited to specific memberships.

State-level data sources also fall short. Traditional licensing board records often omit information on specialties or practice locations—information critical to identifying community-level capacity. Medicaid provider lists exclude professionals not participating in the program. The result is a fragmented patchwork that leaves policy makers unable to answer pressing questions about health care workforce distribution and capacity.

In corporate terms, this resembles a company relying on outdated, incomplete personnel files scattered across different departments, making strategic planning impossible.

**A Standardized Solution: The Cross-Profession Minimum Data Set**

State licensing processes for health professionals represent an ideal opportunity to collect comprehensive workforce data. However, current data collection efforts are fragmented across states and professions. Surveys developed by federal agencies, professional organizations, and researchers often operate in isolation, creating inconsistencies that undermine coordination and hinder effective policy making.

These deficiencies led to the creation of the Cross-Profession Minimum Data Set (CPMDS), a standardized framework developed by seven national regulatory associations: the National Council of State Boards of Nursing, Federation of State Medical Boards, Federation of State Boards of Physical Therapy, Association of Social Work Boards, National Board for Certification in Occupational Therapy, Association of State and Provincial Psychology Boards, and the National Association of Boards of Pharmacy.

Launched in 2024, the CPMDS includes 18 survey questions designed to capture employment and professional practice characteristics critical to understanding the health care workforce environment. The framework aims to standardize information that many state licensing boards already collect. That includes the recommendation that basic demographic information correspond directly to US census categories.

Designed as a flexible survey framework, the CPMDS balances standardization with accommodation for profession-specific nuances. This adaptability is already proving valuable—the physical therapy profession has developed their own consensus version of the CPMDS, with other health professions currently developing their own profession-specific adaptations. When states integrate these tailored versions into license renewal processes, it ensures consistent, comparable data across states and professions while capturing the unique characteristics of each field. The framework also guides private organizations and researchers in developing workforce data systems and enables states to coordinate data sharing, potentially via interstate compacts.

**Early Action And Implementation Successes**

The Utah Health Workforce Advisory Council, established in 2022 by the Utah legislature, officially adopted the CPMDS framework to support the state's workforce data needs. Prior to full adoption, the CPMDS was piloted by the Utah Office of Professional Licensure as part of a behavioral health workforce review. The data captured informed legislative recommendations for behavioral health workforce policy enhancements, many of which became law. Utah's CPMDS has now been implemented during license renewal for physicians and other licensed health professionals. The state recently used these data to assess the need for clinical preceptors; its findings have already informed policy-related planning and recommendations that are being shared with the governor and state legislature.

Additional states, including Indiana, Louisiana, North Carolina, Ohio, and Wisconsin, have begun implementing the CPMDS to collect workforce data for one or more health professions. South Dakota has already enacted related legislation. Wisconsin and Delaware are at various stages of exploring and pursuing legislative action as well.

In Indiana, physician workforce data, collected in conjunction with license renewal under statutory authority since 2018, provide insights that help the state monitor capacity within specific communities and target investments such as Graduate Medical Education expansion. A critical finding: Less than 60 percent of physicians licensed in Indiana actually provide medical care to state residents—information essential for informed workforce policy development.

Indiana's experience demonstrates the value of standardized workforce data. The state has collected similar data for more than a decade, supporting studies on primary care physician participation in addiction treatment, psychiatry workforce shortages, pediatric emergency medicine, and public insurance participation. As more states implement the CPMDS, enhanced data availability will support researchers evaluating health policies and studying workforce models and health care delivery innovations.

**Implementation Pathways And Champions**

CPMDS implementation requires state-level champions among policy makers, regulators, health care leaders, or workforce development officials. While regulators haven't historically viewed workforce data collection as central to their mission, the framework demonstrates how this information enhances public protection goals. Informational resources, including an overview video, have been developed to help spread awareness and increase understanding of the CPMDS among potential champions.

Most states can implement the CPMDS immediately by embedding questions into existing licensing systems or distributing surveys during renewal periods. The framework accommodates different technological capabilities and regulatory structures while maintaining data standardization across jurisdictions.

Think of the CPMDS as a comprehensive human resources information system for health care. Just as well-managed corporations use standardized processes to track employee roles, skills, and locations, the CPMDS creates a unified framework for monitoring health care human resources, enabling better planning and reducing systemic inefficiencies.

**Prioritize Evidence-Based Workforce Planning**

The US public deserves health care workforce planning based on comprehensive, accurate data rather than fragmented information and educated guesses. As health care systems face ongoing workforce challenges, evidence-based planning becomes increasingly critical for ensuring adequate provider availability and appropriate resource allocation.

The CPMDS framework provides a proven solution that early-adopting states are already using to inform policy decisions on clinical preceptors, physician education investments, and scope of practice modifications. The question isn't whether comprehensive workforce data collection is possible—it's whether states will prioritize a systematic approach.

Just as no corporate board of directors would tolerate operating without basic workforce intelligence, Americans shouldn't accept health care planning that lacks fundamental data about provider capacity and distribution.

Readers should ask their state and local officials whether their state is currently using comprehensive workforce data in health care planning decisions. If it isn't leveraging standardized data collection, policy makers should not wait any longer. They should actively explore the CPMDS framework and evidence-based workforce development approaches. Better data enable better planning, and better planning ensures more effective health care delivery for all Americans.